

UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2014
QUALITY IMPROVEMENT INCENTIVE (3) APPLICATION
Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2014

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility has submitted on time a completed application for the Quality Improvement Incentive (1) application and has fulfilled all of the qualifications for QII(1). Qualifying Requirement
- ☐ This facility has submitted on time a completed application for the Quality Improvement Incentive (2) application for at least one of the available options and has fulfilled all of the qualifications for QII(2). Please select which QII(2) option for which you submitted and received reimbursement: Qualifying Requirement
- ☐ QII(2)(i) Nurse Call
- ☐ QII(2)(ii) Patient Lift
- ☐ QII(2)(iii) Bathing
- ☐ QII(2)(iv) Life Enhancement
- ☐ QII(2)(v) Quality Training
- ☐ QII(2)(vi) Van
- ☐ QII(2)(vii) Info Systems
- ☐ QII(2)(viii) HVAC
- ☐ QII(2)(ix) Dining Enhancement
- ☐ QII(2)(x) Outcome Proven Awards
- ☐ QII(2)(xi) Worker Immunizations
- ☐ This Facility has created and implemented a residents' choice program. *(A brief description of our residents' choice program is attached.)*
- ☐ This facility has a demonstrated process by which its residents' choice program is assessed and measured. *(A brief description of this process, including an example demonstrating which options are presented, which option(s) are most selected, and how special requests are fulfilled, is attached.)* Qualifying Requirement
- ☐ This facility has documented the residents' choice program for all of the following areas:
- ☐ Awake Time (when the resident wants to wake up and/or go to sleep)
- ☐ Meal Time
- ☐ Bath Time

Please ensure that the attached documents do not exceed a total of 12 pages.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify.

Fax to: 801-323-1595

<or>

Mail instructions: <http://health.utah.gov/medicaid/stplan/longtermcare.htm>